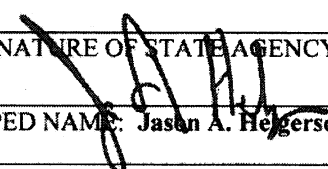
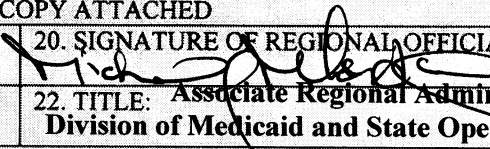


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-22	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/13-09/30/13 \$ (34.5M) b. FFY 10/01/13/09/30/14 \$ (68.9M)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 4(d), A(7), A(7.2), A(7.3), A(7.4) **Please see remarks		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B: 4(d), A(7)	
10. SUBJECT OF AMENDMENT: 2% Across the Board Reduction – 2-Year Extension - NI (FMAP = 50%)			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: June 26, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: November 06, 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 01, 2013		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Michael Melendez		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: **The SPA continues the 2% reduction uniformly across most payments made under the State's Non-Institutional State Plan Amendment (4.19-B) for non-institutional. Such payment reductions are to commence with payments made on or after April 1, 2013 through March 31, 2015.			